



## **Better Health Workgroup**

Tuesday, September 15<sup>th</sup> 2015 - 9:00 a.m. – Noon  
West Virginia University Health Science Center – Charleston, West Virginia

### **MEETING SUMMARY NOTES**

#### **Today's Expected Results:**

- Strengthen working relationships among workgroup members
- Develop an increased understanding of the state of tobacco in West Virginia
- Provide recommendations for the design of a system that delivers coordinated and integrated care in West Virginia and impacts individual and population health
- Identify questions and make recommendations to appropriate workgroups related to other elements of a model that could influence population health
- Identify next steps, materials and expertise needed for our next session, unresolved issues regarding the proposed system of coordinated care and preparation for October's focus on behavioral health

**Co-Chairs:** Lesley Cottrell and Anne Williams

**Facilitator:** 26 people – 21 in person and 5 electronically

TOPIC	OVERVIEW/DISCUSSION/DECISIONS
<b>Welcome, Introductions and Opening Remarks</b>	The third SIM Better Health Workgroup meeting opened with welcoming remarks. Joshua Austin, SIM Project Coordinator, was recognized for his role as liaison between all workgroups. The agenda with expected results for the meeting and ground rules were reviewed with workgroup members.
<b>Review of Workgroup Meeting Results to Date</b>	<p>Mr. Austin provided a PowerPoint presentation summarizing the results of all SIM workgroups to date. Five key themes for the SIM model design have emerged. These are as follows:</p> <ol style="list-style-type: none"> <li>1. Must include care coordination / coordinators</li> <li>2. Must be an integration of behavioral health and physical health</li> <li>3. Must be alignment of provider and payor quality measures</li> <li>4. Must include telehealth / telemedicine</li> <li>5. HIT must be a backbone, aid to this model design and its deployment</li> </ol>
<b>West Virginia Tobacco Prevention Plan Proposal</b>	Bruce Adkins, Interim Director of the WV Bureau for Public Health Office of Community Health Systems and Health Promotion, provided an informative PowerPoint presentation on the state of tobacco in West Virginia. The presentation outlined specifics of the proposed tobacco section of the State Health Improvement Plan (SHIP). Q&A followed the presentation.
<b>Designing a System that Delivers Coordinated and Integrated Care in West Virginia and Impacts Individual and Population Health</b>	<p>In small groups, workgroup members discussed questions related to designing a system that delivers coordinated care in West Virginia and impacts individual and population health. Small group discussion guidelines were provided to help direct workgroup interaction. These small groups then provided a brief report to the whole workgroup.</p> <p><b>The responses below have been lightly edited for clarity.</b></p> <ol style="list-style-type: none"> <li>1. What would you keep in this model? <ul style="list-style-type: none"> <li>• Keep the components listed (mentioned by two small groups)</li> <li>• Medical Neighborhood (MN)</li> <li>• Specialty care</li> <li>• Having basic primary care model instead of a basic medical model</li> </ul> </li> </ol>

	<p>2. What would you remove from the model?</p> <ul style="list-style-type: none"> <li>• Emphasis on a medical model: repeatedly comes up that there should be a health focus in other workgroup discussions</li> <li>• Need a new visual that integrates the systems, based on socioecological model (i.e., policy, organizational, interpersonal, individual, etc.)</li> <li>• Nothing assuming that all providers accept Medicaid and the Medical Neighborhood takes place in a primary care setting</li> </ul> <p>3. What would you add to the model?</p> <ul style="list-style-type: none"> <li>• We need definitions of each element of the model</li> <li>• Community partnerships with non-profit agencies, etc.</li> <li>• Alternative complimentary evidence-based services</li> <li>• Use the term “health neighborhood” instead of medical neighborhood</li> <li>• System that provides prevention and management throughout the life span</li> <li>• Add judicial component</li> <li>• Transportation – all state agencies</li> <li>• Socioecological model basis from the U.S. Agency for Healthcare Research and Quality</li> <li>• Local hubs with regional coordination</li> <li>• Define extended care (e.g., hospice, telehealth, LTC, rehab, PT / OT, drug rehab, etc.)</li> <li>• Hospital care</li> <li>• Payors</li> <li>• MCO for Medicaid (need claims data, etc.)</li> <li>• Local / state / regional levels to collaborative partners, including government</li> <li>• Education – community /county / college</li> <li>• Individual bureaus</li> <li>• Community health as possibly another box (including hospice, dietary, etc.) supports to add so social determinants of health are addressed</li> </ul>
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	<ul style="list-style-type: none"> <li>• Telemedicine / telehealth / technology to visualize some of the services, use as a connector to help facilitate the transitions of care and care coordination. It would be helpful to have a listing of other telehealth facilities and the methods / strategies being used to help link services</li> <li>• Connection to specialty care is important alongside the advanced primary care model that centers around the patient's needs</li> </ul> <p>4. What would be needed to sustain the significance of this model?</p> <ul style="list-style-type: none"> <li>• Policy creation using the Health in All Policies (HiAP) concept</li> <li>• Increase participation of West Virginia Health Innovation Collaborative, including follow-up meetings regionally / monthly</li> <li>• Needs to be a win / win</li> <li>• Money needs to follow the model</li> <li>• Best practice policy</li> <li>• Care manager / coordination</li> <li>• Provider education – medical school and clinic level</li> <li>• Payor / provider / clinician engagement and buy-in</li> <li>• Policy support</li> <li>• Provider buy-in</li> <li>• Best practices / research (effective)</li> <li>• Funding</li> <li>• Starts with provider buy-in. Have to have the buy-in of primary care providers. If they do not see the benefit of the system, they will not promote it. Engagement and an empowered support team is important in this relationship.</li> <li>• Enhance patient-provider relationship and communications. Need a grounded comfort level in health care. Incorporate shared decision-making in the care coordination team in terms of improving the patient's overall health.</li> </ul> <p>5. What questions do you have about a coordinated and integrated system of care in West Virginia that impacts individual and population health?</p>
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	<ul style="list-style-type: none"> <li>• Who is responsible for creating, implementing and integrating the model?</li> <li>• How do we make it evidence-based?</li> <li>• How do we measure it?</li> <li>• How do we promote it?</li> <li>• Is there additional funding needed?</li> <li>• How will the allocation of resources be decided both statewide and regionally?</li> <li>• How will all this be communicated between state and region?</li> <li>• How do we balance scarce resources with need?</li> <li>• How do we get policies to support needs? (i.e., legislative, organizational, local and payor policy - not all inclusive.)</li> <li>• What roles / obligations do local health departments play / have?</li> <li>• How does payment for health care services need to be changed to support the model?</li> <li>• Is incorporation of employer / employee health and wellness programs a possibility?</li> <li>• Define medical neighborhood (i.e., primary care, health centers, local health departments)</li> <li>• Define long-term / extended care (What comprises these? What might remain uncovered?)</li> <li>• Define specialty care (What comprises these? What might remain uncovered?)</li> <li>• Referrals – how to be efficient / effective? How to engage providers?</li> <li>• Who will be the group(s) to make this all happen? Who is the integrator—the person on the ground making sure things are integrated and continuing?</li> <li>• Significance of the primary care provider’s involvement – may not necessarily need to be paid if they have an active part in the model / plan. This model would require both financial and non-financial incentives that would meet people where they are in terms of their readiness to make change(s).</li> </ul>
<b>Final Comments, Next Steps, Action Items, Assignments and Check Out</b>	<ul style="list-style-type: none"> <li>• <b>For October, the Better Health Workgroup meeting time and agenda are still to be determined. The workgroup will be notified as soon as final arrangements are made.</b></li> </ul>
<b>Parking Lot</b>	None

## Group Checkout (Verbatim Responses)

<i>What worked well today?</i>	<i>What would you change for the next meeting?</i>
<ul style="list-style-type: none"> <li>• Great ideas</li> <li>• Variety of backgrounds represented</li> <li>• It was great!</li> <li>• Good group collaboration</li> <li>• Presentation on tobacco</li> <li>• Exercise on reviewing model</li> <li>• Good dynamics</li> <li>• Positive energy</li> <li>• My table came up with an innovative alternative</li> <li>• Nice job</li> <li>• Good meeting</li> <li>• Loved the snacks – thank you</li> <li>• Good group discussion</li> <li>• Snacks</li> <li>• Good group collaboration</li> <li>• Loved (as always) the schedule</li> <li>• Table exercises were pertinent</li> <li>• Thanks for the snacks</li> <li>• Good group discussion</li> <li>• Very informative</li> <li>• Group activities to brainstorm</li> <li>• Results of all groups</li> <li>• Break out groups great</li> <li>• Great forum input!</li> <li>• Consideration of other models</li> </ul>	<ul style="list-style-type: none"> <li>• Needed more time in small groups</li> <li>• Start the meetings at 9:30 to give those who drive great distance time to arrive</li> <li>• Too cold in the room</li> <li>• No requested feedback from group on how to address tobacco issues</li> <li>• Cold room</li> <li>• Integrate previous recommendations into models / questions to contemplate – still using “medical” not “health”</li> <li>• Use the feedback we provided so we no longer talk about a <u>medical</u> model</li> <li>• Room was chilly – but realize that is hard to control</li> <li>• Please convey concerns of this heavy <u>medical</u> model that continues to be proposed</li> <li>• We need definitions with all handouts</li> <li>• Needed more direction initially about what was going to be discussed in small groups</li> <li>• Didn’t realize we would not be focusing on tobacco – had focused on obesity in previous meeting</li> <li>• Had more to say / suggest / ask about tobacco issues</li> <li>• The room was really cold</li> <li>• Use “health neighborhood” term</li> <li>• Coffee</li> <li>• Coffee available ☺</li> </ul>

<ul style="list-style-type: none"> <li>• Review of work from other groups</li> <li>• Good discussion</li> <li>• Great discussion on model and recommended edits</li> <li>• Please continue SIM workgroup updates at beginning of meeting</li> </ul>	<ul style="list-style-type: none"> <li>• Continuing confusion regarding medical neighborhood definition / direction</li> <li>• Meeting attendance down</li> <li>• Lots of meetings</li> </ul>
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#### **Suggested Ideas for Additional Workgroup Members**

- None